2010-2011 Seasonal Flu Vaccine Administration Record

Information about the person to receive vaccine (please print): ***Required Fields**

Name: (Last, First, MI)*			**DOB:** (MM/DD/YY)*	**Sex:** (Circle)* M F
Address:*				
City:*	**State:***	**Zip:***	**Phone:*** ( )	

INSURANCE INFORMATION: *Include the prefix and suffix with the insurance ID number, if applicable.*

Insurance Company:*	**Member ID #:***	**Group ID #:**

If Patient is not the Subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*			**Subscriber's DOB:**	**Sex:** (Circle)* M F
Subscriber's Address:* **(If different from address above)**				
City:*	**State:***	**Zip: ***	**Phone:*** ( )	
Patient Relationship to Subscriber:* (Circle)	**Spouse**	**Child**	**Other**	

OTHER INSURANCE INFORMATION: *Include the prefix and suffix with the insurance ID number, if applicable.*

Insurance Company:*	**Member ID #:***	**Group ID #:**

I give permission for my insurance company to be billed.

X_____ **Date:** _____

(Signature of patient, parent or legal guardian)

****

For Clinic/Office Use: Contact Person: Jillian Schofield, RN Phone Number: 781-751-9224

Vaccine Name:	Vaccine Manufacturer:	Vaccine Lot Number:	Date Vaccine Administered:*	Vaccine Type:	Injection Site: * (Circle)	Injection Route:* (Circle)
Seasonal Influenza Fluzone	Sanofi Pasteur	UH224AB Exp 06/30/2011	(MM/DD/YY)	Dose #1	Right Arm Left Arm Right Leg Left Leg	Intramuscular Intranasal

Clinic Site Name: Dedham Health Department **Site PIN#** 10349

Clinic Address: 26 Bryant Street, Dedham MA 02026

Date Vaccine Information Statement (VIS) given: _____ **Date on VIS: 08 /10/2010**

Signature of Vaccine Administrator: _____ **Date:** _____